CALIFORNIA CODE OF REGULATIONS

TITLE 22

DIVISION 7

CHAPTER 1
HEALTH PLANNING AND RESOURCES DEVELOPMENT

ARTICLE 5
CERTIFICATE OF NEED

AND

CHAPTER 10
HEALTH FACILITY DATA

ARTICLE 8
PATIENT DATA REPORTING REQUIREMENTS

November 2006

ARTICLE 5: CERTIFICATE OF NEED

90417. Special Fees.

(a) Health Facilities, except those exempt by law and long-term care facilities (as defined by Section 97005(d), California Code of Regulations), shall be charged a special fee as follows:

(1) For the last fiscal year ending on or before June 30, of the preceding calendar year the fee shall be 0.034 percent of the gross operating cost for the provision of health care services as determined by the Office.

(b) Long-term care facilities (as defined by Section 97005(d), California Code of Regulations), except those exempt by law, shall be charged a special fee as follows:

(1) For the last fiscal year ending on or before June 30, of the preceding calendar year the fee shall be 0.034 percent of the gross operating cost for the provision of health care services as determined by the Office.

(c) Freestanding ambulatory surgery clinics as defined in Health and Safety Code 128700(e) shall be charged a special fee that shall be established at an amount equal to the number of ambulatory surgery data records submitted to the Office pursuant to Section 128737 for encounters in the preceding calendar year multiplied by fifty cents ($.50).

Note: Authority: Sections 127150, 127280, 128700, and128810, Health and Safety Code.
Reference: Sections 127280 and 128737, Health and Safety Code

ARTICLE 8: PATIENT DATA REPORTING REQUIREMENTS

97210. Contact Person, User Account Administrator, Designated Agent, and Facility Identification Number.

(a) Each reporting facility shall designate a primary contact person and shall notify the Office's Patient Data Program in writing, by electronic mail or through the Medical Information Reporting for California (MIRCal) system of the designated person's name, title, telephone number(s), mailing address, and electronic mail address. The designated person will be sent time-sensitive electronic mail regarding the facility's data submission, including reminder notices, acceptance and rejection notifications, and extension information.

(b) Each reporting facility shall notify the Office's Patient Data Program in writing, by electronic mail, or through the MIRCal system within 15 days after any change in the person designated as the primary contact person, or in the designated primary person's name, title, telephone number(s), mailing address or electronic mail address.

(c) Each reporting facility beginning or resuming operations, whether in a newly constructed facility or in an existing facility, shall notify the Office's Patient Data Program in writing, by electronic mail or through the MIRCal system within 30 days after its first day of operation of the designated primary contact person and the facility administrator.

(d) Each reporting facility shall designate up to three User Account Administrators pursuant to Subsection (f) of Section 97246. Each reporting facility shall notify the Office's Patient Data Program in writing, by electronic mail or through the MIRCal system within 15 days after any change in a designated user account administrator's name, title, telephone number(s), mailing address, or electronic mail address.

(e) Each reporting facility may submit its own data report to the Office's Patient Data Program, or it may designate an agent for this purpose. The reporting facility shall be responsible for ensuring compliance with regulations and reporting requirements when an agent is designated pursuant to Subsection (b) of Section 97246.

(1) Each reporting facility shall be provided a facility identification number that shall be used to submit data to the Office.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Sections 128700, 128735, 128736, and 128737, Health and Safety Code.

97211. Reporting Periods and Due Dates.

(a) The prescribed reporting periods are:

(1) Calendar semiannual for Hospital Discharge Abstract Data reports,

which means that there are two reporting periods each year, consisting of discharges occurring January 1 through June 30 and discharges occurring July 1 through December 31.

(2) Calendar quarterly for Emergency Care Data reports, which means there are four reporting periods each year, consisting of encounters occurring January 1 through March 31, encounters occurring April 1 through June 30, encounters occurring July 1 through September 30, and encounters occurring October 1 through December 31.

(3) Calendar quarterly for Ambulatory Surgery Data reports, from a hospital or from a freestanding ambulatory surgery clinic, which means there are four reporting periods each year, consisting of encounters occurring January 1 through March 31, encounters occurring April 1 through June 30, encounters occurring July 1 through September 30, and encounters occurring October 1 through December 31.

(b) Where there has been a change in the licensee, the effective date of the change shall constitute the start of the reporting period for the new licensee. The end of the first reporting period for the new licensee shall be the end of the prescribed reporting period. The final day of the reporting period for the previous licensee shall be the last day their licensure was effective.

(c) Report due dates:

(1) For Hospital Discharge Abstract Data reports, for discharges occurring on or after January 1, 2003, and all subsequent report periods, the report due date shall be three months after the end of each reporting period; thus the due date for the January 1 through June 30 reports is September 30 of the same year and the due date for the July 1 through December 31 reports is March 31 of the following year.

(2) For Emergency Care Data reports, for encounters occurring on or after October 1, 2004, and all subsequent report periods, the report due date shall be 45 days after the end of each reporting period; thus the due date for the January 1 through March 31 reports is May 15 of the same year, the due date for the April 1 through June 30 reports is August 14 of the same year, the due date for the July 1 through September 30 reports is November 14 of the same year, and the due date for the October 1 through December 31 reports is February 14 of the following year.

(3) For Ambulatory Surgery Data reports, for encounters occurring on or after October 1, 2004, and all subsequent report periods, the report due date shall be 45 days after the end of each reporting period; thus the due date for the January 1 through March 31 reports is May 15 of the same year, the due date for the April 1 through June 30 reports is August 14 of the same year, the due date for the July 1 through September 30 reports is November 14 of the same year, and the due date for October 1 through December 31 reports is February 14 of the following year.

(d) Data reports shall be filed, as defined by Subsection (j) of Section 97005, by the date the data report is due. Where a reporting facility has been granted an extension, pursuant to Section 97241, the ending date of the extension shall constitute the new due date for that data report.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97212. Definitions, as used in this Article.

(a) Ambulatory Surgery (AS) Data Record. The Ambulatory Surgery Data Record consists of the set of data elements related to an encounter, as specified in Subsection (a) of Section 128737 of the Health and Safety Code and as defined in Sections 97251-97265.

(b) CPT-4. The Current Procedural Terminology, 4th Edition, is published and maintained by the American Medical Association. It is a standard medical code set for healthcare services or procedures in non-inpatient settings.

(c) Days. Days, as used in this article, are defined as calendar days unless otherwise specified.

(d) Designated Agent. An entity designated by a reporting facility to submit that reporting facility's data records to the Office's Patient Data Program.

(e) Discharge. A discharge is defined as an inpatient who:

(1) is formally released from the care of the hospital and leaves the hospital, or

(2) is transferred within the hospital from one type of care to another type of care, as defined by Subsection (x) of Section 97212, or

(3) leaves the hospital against medical advice, without a physician's order or is a psychiatric patient who is discharged as away without leave (AWOL), or

(4) has died.

(f) DRG. Diagnosis Related Groups is a classification scheme with which to categorize inpatients according to clinical coherence and expected resource intensity, as indicated by their diagnoses, procedures, age, sex, and disposition, and was established and is revised annually by the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS), formerly known as the U.S. Health Care Financing Administration.

(g) Do Not Resuscitate (DNR) Order. A DNR order is a directive from a physician in a patient's current inpatient medical record instructing that the patient is not to be resuscitated in the event of a cardiac or pulmonary arrest. In the event of a cardiac or pulmonary arrest, resuscitative measures include, but are not limited to, the following: cardiopulmonary resuscitation (CPR), intubation, defibrillation, cardioactive drugs, or assisted ventilation.

(h) Emergency Care Data Record. The Emergency Care Data Record consists of the set of data elements related to an encounter, as specified in Subsection (a) of Section 128736 of the Health and Safety Code and as defined in Sections 97251-97265.

(i) Emergency Department (ED). Emergency Department means, in a hospital licensed to provide emergency medical services, the location in which those services are provided, as specified in Subsection (c) of Section 128700 of the Health and Safety Code. For the purposes of this chapter, this includes emergency departments providing standby, basic, or comprehensive services.

(j) Encounter. An encounter is a face-to-face contact between an outpatient and a provider.

(k) Error. Error means any record found to have an invalid entry or to contain incomplete data or to contain illogical data.

(l) Facility Identification Number. A unique six-digit number that is assigned to each facility and shall be used to identify the facility.

(m) Freestanding Ambulatory Surgery Clinic. Freestanding ambulatory surgery clinic means a surgical clinic that is licensed by the state under paragraph (1) of subdivision (b) of Section 1204 of the Health and Safety Code. This type of facility is commonly known as a freestanding ambulatory surgery center.

(n) Hospital Discharge Abstract Data Record: The Hospital Discharge Abstract Data Record consists of the set of data elements related to a discharge, as specified in Subsection (g) of Section 128735 of the Health and Safety Code and as defined by Sections 97216-97233 for Inpatients.

(o) ICD-9-CM. The International Classification of Diseases, 9th Revision, Clinical Modification, published by the U.S. Department of Health and Human Services. Coding guidelines and annual revisions to ICD-9-CM are made nationally by the "cooperating parties" (the American Hospital Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, and the American Health Information Management Association).

(p) Inpatient. An inpatient is defined as a baby born alive in this hospital or a person who was formally admitted to the hospital for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer.

(q) Licensee. Licensee means an entity that has been issued a license to operate a facility as defined by Subsection (e) or (g) of Section 128700 of the Health and Safety Code.

(r) MIRCal. MIRCal means the OSHPD Medical Information Reporting for California system that is the online transmission system through which reports are submitted using an Internet web browser either by file transfer or data entry. It is a secure means of electronic transmission of data in an automated environment and allows facilities to edit and correct data held in a storage database until reports meet or exceed the Approval Criteria specified in Section 97247.

(s) Outpatient. An outpatient means:

(1) a person who has been registered or accepted for care but not formally
admitted as an inpatient and who does not remain over 24 hours, as specified in Subsection (a)(2) of Section 70053 of Title 22 of the California Code of Regulations, or

(2) a patient at a freestanding ambulatory surgery clinic who has been registered and accepted for care.

(t) Provider. A provider is the person who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient. This would include a practitioner licensed as a Medical Doctor (M.D.), a Doctor of Osteopathy, (D.O.), a Doctor of Dental Surgery (D.D.S.), or a Doctor of Podiatric Medicine (D.P.M.).

(u) Record. A record is defined as the set of data elements specified in Subsection (g) of Section 128735, Subsection (a) of Section 128736, or Subsection (a) of Section 128737 of the Health and Safety Code, for one discharge or for one encounter.

(v) Report. A report is defined as the collection of all Hospital Discharge Abstract Data Records, or all Emergency Care Data Records, or all Ambulatory Surgery Data Records required to be submitted by a reporting facility for one reporting period. A report contains only one type of record.

(w) Reporting Facility. Reporting facility means a hospital or a freestanding ambulatory surgery clinic required to submit data records, as specified in Subsection (g) of Section 128735, or Subsection (a) of Section 128736, or Subsection (a) of Section 128737 of the Health and Safety Code.

(x) Type of Care. Type of care in hospitals is defined as one of the following:

(1) Skilled nursing/intermediate care. Skilled nursing/intermediate care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classifications of skilled nursing or intermediate care, as defined by paragraphs (2), (3), or (4) of Subdivision (a) of Section 1250.1 of the Health and Safety Code. Skilled nursing/intermediate care also means inpatient care that is provided to inpatients occupying general acute care beds that are being used to provide skilled nursing/intermediate care to those inpatients in an approved swing bed program.

(2) Physical rehabilitation care. Physical rehabilitation care means inpatient care that is provided to inpatients occupying beds included on a hospital's license within the general acute care classification, as defined by paragraph (1) of Subdivision (a) of Section 1250.1 of the Health and Safety Code, and designated as rehabilitation center beds, as defined by Subsection (a) of Section 70034 and by Section 70595 of Title 22 of the California Code of Regulations.

(3) Psychiatric care. Psychiatric care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classification of acute psychiatric beds, as defined by paragraph (5) of Subdivision (a) Section 1250.1 of the Health and Safety Code, and psychiatric health facility, as defined by Subdivision (a) of Section 1250.2 of the Health and Safety Code.

(4) Chemical dependency recovery care. Chemical dependency recovery care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license as chemical dependency recovery beds, as defined by paragraph (7) of Subdivision (a) of Section 1250.1 of the Health and Safety Code and Subdivisions (a), (c), or (d) of Section 1250.3 of the Health and Safety Code.

(5) Acute care. Acute care, as defined by paragraph (1) of Subdivision (a) of Section 1250.1 of the Health and Safety Code, means all other types of inpatient care provided to inpatients occupying all other types of licensed beds in a hospital, other than those defined by paragraphs (1), (2), (3) and (4) of Subsection (x) of this section.

(y) User Account Administrator. A healthcare facility representative responsible for maintaining the facility's MIRCal user accounts and user account contact information.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 1250, 1250.1, 128700, 128735, 128736, and 128737, Health and Safety Code.

97213. Required Reporting.

(a) (1) Hospital Discharge Abstract Data: Each hospital shall submit hospital discharge abstract data record, as specified in Subsection (g) of Section 128735 of the Health and Safety Code, for each inpatient discharged during the semiannual reporting period, according to the format specified in Subsection (a) of Section 97215 and by the dates specified in Subsection (c)(1) of Section 97211.

(2) Emergency Care Data: Each hospital shall submit an emergency care data record, as specified in Subsection (a) of Section 128736 of the Health and Safety Code, for each encounter during the quarterly reporting period, according to the format specified in Subsection (b) of Section 97215 and by the dates specified in Subsection (c)(2) of Section 97211. A hospital shall not report an Emergency Care Data Record if the encounter resulted in a same-hospital admission.

(3) Ambulatory Surgery Data: Each hospital and freestanding ambulatory surgery clinic shall submit an ambulatory surgery data record, as specified in Subsection (a) of Section 128737 of the Health and Safety Code, for each encounter during which at least one ambulatory surgery procedure is performed, during the quarterly reporting period, according to the format specified in Subsection (c) of Section 97215 and by the dates specified in Subsection (c)(3) of Section 97211. An ambulatory surgery procedure is defined by Subsection (a) of Section 128700 of the Health and Safety Code as those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic. A hospital shall not report an Ambulatory Surgery Data Record if the encounter resulted in a same-hospital admission.

(b) A hospital shall separately identify records of inpatients being discharged from the acute care type of care, as defined by paragraph (5) of Subsection (x) of Section 97212. The hospital shall identify these records by recording a "1" on each of these records as specified in the Format and Specifications for Online Transmission in Section 97215.

(c) A hospital shall separately identify records of inpatients being discharged from the skilled nursing/intermediate care type of care, as defined by paragraph (1) of Subsection (x) of Section 97212. The hospital shall identify these records by recording a "3" on each of these records as specified in the Format and Specifications for Online Transmission in Section 97215.

(d) A hospital shall separately identify records of inpatients being discharged from the psychiatric care type of care, as defined by paragraph (3) of Subsection (x) of Section 97212. The hospital shall identify these records by recording a "4" on each of these records as specified in the Format and Specifications for Online Transmission in Section 97215.

(e) A hospital shall separately identify records of inpatients being discharged from the chemical dependency recovery care type of care, as defined by paragraph (4) of Subsection (x) of Section 97212. The hospital shall identify these records by recording a "5" on each of these records as specified in the Format and Specifications for Online Transmission in Section 97215.

(f) A hospital shall separately identify records of inpatients being discharged from the physical rehabilitation care type of care, as defined by paragraph (2) of Subsection (x) of Section 97212. The hospital shall identify these records by recording a "6" on each of these records as specified in the Format and Specifications for Online Transmission in Section 97215.

(g) Licensees operating and maintaining more than one physical plant on separate premises under a single consolidated license who choose to file separate data reports for each location must request, in writing, a modification to file separate data reports for each location. A licensee granted a modification under this paragraph shall be responsible for all regulatory requirements for each separate report. Separate extension requests, filed under the provisions of Section 97241, shall be required for each report, and penalties, assessed pursuant to Section 97250, shall be assessed on each delinquent report.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97215. Format.

(a) Hospital Discharge Abstract Data reports for discharges occurring on or after January 1, 2005, shall comply with the Office's Format and File Specifications for MIRCal Online Transmission Patient Discharge Data, dated April 2004, and hereby incorporated by reference.

(b) Emergency Care Data reports for encounters occurring on or after January 1, 2005, shall comply with the Office's Format and File Specifications for MIRCal Online Transmission Emergency Care and Ambulatory Surgery Data, dated April 2004, and hereby incorporated by reference.

(c) Ambulatory Surgery Data reports for encounters occurring on or after January 1, 2005, shall comply with the Office's Format and File Specifications for MIRCal Online Transmission Emergency Care and Ambulatory Surgery Data, dated April 2004.

(d) The Office's Format and File Specifications for MIRCal Online Transmission as named in (a), (b), and (c) are available for download from the MIRCal website. The Office will make a hardcopy of either set of Format and File Specifications for MIRCal Online Transmission available to a reporting facility or designated agent upon request.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97216. Definition of Data Element for Inpatients—Date of Birth.

The patient's birth date shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year of birth. The numeric form for days and months from 1 to 9 must have a zero as the first digit. When the complete date of birth is unknown, as much of the date as is known shall be reported. At a minimum, an approximate year of birth shall be reported. If only the age is known, the estimated year of birth shall be reported. If the month and year of birth are known, and the exact day is not, the year, the month, and zeros for the day shall be reported.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97217. Definition of Data Element for Inpatients—Sex.

The patient's gender shall be reported as male, female, other, or unknown. "Other" includes sex changes, undetermined sex, and live births with congenital abnormalities that obscure sex identification. "Unknown" indicates that the patient's sex was not available from the medical record.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97218. Definition of Data Element for Inpatients—Race.

Effective with discharges on January 1, 1995, the patient's ethnic and racial background shall be reported as one choice from the following list of alternatives under ethnicity and one choice from the following list of alternatives under race:

(a) Ethnicity:

(1) Hispanic. A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

(2) Non-Hispanic.

(3) Unknown.

(b) Race:

(1) White. A person having origins in or who identifies with any of the original caucasian peoples of Europe, North Africa, or the Middle East.

(2) Black. A person having origins in or who identifies with any of the black racial groups of Africa.

(3) Native American/Eskimo/Aleut. A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

(4) Asian/Pacific Islander. A person having origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

(5) Other. Any possible options not covered in the above categories.

(6) Unknown.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97219. Definition of Data Element for Inpatients—ZIP Code.

The "ZIP Code," a unique code assigned to a specific geographic area by the U.S. Postal Service, for the patient's usual residence shall be reported for each patient discharge. Foreign residents shall be reported as "YYYYY" and unknown ZIP Codes shall be reported as "XXXXX." If the city of residence is known, but not the street address, report the first three digits of the ZIP Code, and the last two digits as zeros. Hospitals shall distinguish the "homeless" (patients who lack a residence) from other patients lacking a numeric ZIP Code of residence by reporting the ZIP Code of homeless patients as "ZZZZZ." If the patient has a 9-digit ZIP Code, only the first five digits shall be reported.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97220. Definition of Data Element for Inpatients—Patient Social Security Number.

The patient's social security number is to be reported as a 9-digit number. If the patient's social security number is not recorded in the patient's medical record, the social security number shall be reported as "not in medical record," by reporting the social security number as "000000001." The number to be reported is to be the patient's social security number, not the social security number of some other person, such as the mother of a newborn or the insurance beneficiary under whose account the hospital's bill is to be submitted.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97221. Definition of Data Element for Inpatients—Admission Date.

The patient's date of admission shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit. For discharges representing a transfer of a patient from one type of care within the hospital to another type of care within the hospital, as defined by Subsection (x) of Section 97212 and reported pursuant to Section 97212, the admission date reported shall be the date the patient was transferred to the type of care being reported on this record.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97222. Definition of Data Element for Inpatients—Source of Admission.

Effective with discharges on or after January 1, 1997, in order to describe the patient's source of admission, it is necessary to address three aspects of the source: first, the site from which the patient originated; second, the licensure of the site from which the patient originated; and, third, the route by which the patient was admitted. One alternative shall be selected from the list following each of three aspects:

(a) The site from which the patient was admitted.

(1) Home. A patient admitted from the patient's home, the home of a relative or friend, or a vacation site, whether or not the patient was seen at an outpatient clinic or physician's office, or had been receiving home health services or hospice care at home.

(2) Residential Care Facility. A patient admitted from a facility in which the patient resides and that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

(3) Ambulatory Surgery. A patient admitted after treatment or examination in an ambulatory surgery facility, whether hospital-based or a freestanding

licensed ambulatory surgery clinic or certified ambulatory surgery center. Excludes outpatient clinics and physicians' offices not licensed and/or certified as an ambulatory surgery facility.

(4) Skilled Nursing/Intermediate Care. A patient admitted from skilled nursing care or intermediate care, whether freestanding or hospital-based, or from a Congregate Living Health Facility, as defined by Subdivision (i) of Section 1250 of the Health and Safety Code.

(5) Acute Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care of a medical/surgical nature, such as in a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of a hospital.

(6) Other Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care not of a medical/surgical nature, such as in a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit.

(7) Newborn. A baby born alive in this hospital.

(8) Prison/Jail. A patient admitted from a correctional institution.

(9) Other. A patient admitted from a source other than mentioned above. Includes patients admitted from a freestanding, not hospital-based, inpatient hospice facility.

b) Licensure of the site.

(1) This Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of this hospital. Includes all newborns.

(2) Another Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of some other hospital.

(3) Not a Hospital. The site from which the patient was admitted was not operated under the license of a hospital. Includes all patients admitted from Home, Residential Care, Prison/Jail, and Other sites. Includes patients admitted from Ambulatory Surgery or Skilled Nursing/Intermediate Care sites that were not operated under the authority of the license of any hospital. Excludes all patients admitted from Acute Hospital Care or Other Hospital Care.

(c) Route of admission.

(1) Your Emergency Room. Any patient admitted as an inpatient after being treated or examined in this hospital's emergency room. Excludes patients seen in the emergency room of another hospital.

(2) Not Your Emergency Room. Any patient admitted as an inpatient without being treated or examined in this hospital's emergency room. Includes patients seen in the emergency room of some other hospital and patients not seen in any emergency room.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97223. Definition of Data Element for Inpatients—Type of Admission.

Effective with discharges on January 1, 1995, the patient's type of admission shall be reported using one of the following categories:

(a) Scheduled. Admission was arranged with the hospital at least 24 hours prior to the admission.

(b) Unscheduled. Admission was not arranged with the hospital at least 24 hours prior to the admission.

(c) Infant. An infant less than 24 hours old.

(d) Unknown. Nature of admission not known. Does not include stillbirths.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97224. Definition of Data Element for Inpatients—Discharge Date.

The patient's date of discharge shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97225. Definition of Data Element for Inpatients—Principal Diagnosis and Whether the Condition was Present at Admission.

(a) The patient's principal diagnosis, defined as the condition established, after study, to be the chief cause of the admission of the patient to the facility for care, shall be coded according to the ICD-9-CM.

(b) Effective with discharges on or after January 1, 1996, whether the patient's principal diagnosis was present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97226. Definition of Data Element for Inpatients—Other Diagnoses and Whether the Conditions were Present at Admission.

(a) The patient's other diagnoses are defined as all conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are to be excluded. Diagnoses shall be coded according to the ICD-9-CM. ICD-9-CM codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) and codes from Morphology of Neoplasms (M800-M997 codes) shall not be reported as other diagnoses.

(b) Effective with discharges on or after January 1, 1996, whether the patient's other diagnoses were present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97227. Definition of Data Element for Inpatients—External Cause of Injury.

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported on the record for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the discharge record. To assure uniform reporting of E-codes, when multiple codes are required to completely classify

the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97228. Definition of Data Element for Inpatients—Principal Procedure and Date.

The patient's principal procedure is defined as one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure. Procedures shall be coded according to the ICD-9-CM. If only non-therapeutic procedures were performed, then a non-therapeutic procedure should be reported as the principal procedure, if it was a significant procedure. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. The date the principal procedure was performed shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97229. Definition of Data Element for Inpatients—Other Procedures and Dates.

All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. Procedures shall be coded according to the ICD-9-CM. The dates shall be recorded with the corresponding other procedures and be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97230. Definition of Data Element for Inpatients—Total Charges.

The total charges are defined as all charges for services rendered during the length of stay for patient care at the facility, based on the hospital's full established rates. Charges shall include, but not be limited to, daily hospital services, ancillary

services, and any patient care services. Hospital-based physician fees shall be excluded. Prepayment (e.g., deposits and prepaid admissions) shall not be deducted from Total Charges. If a patient's length of stay is more than 1 year (365 days), report Total Charges for the last year (365 days) of stay only.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97231. Definition of Data Element for Inpatients—Disposition of Patient.

Effective with discharges on or after January 1, 1997, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the reporting facility, shall be reported as one of the following:

(a) Routine Discharge. A patient discharged from this hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office or a clinic shall be included. Excludes patients referred to a home health service.

(b) Acute Care Within This Hospital. A patient discharged to inpatient hospital care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit within this reporting hospital.

(c) Other Type of Hospital Care Within This Hospital. A patient discharged to inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit within this reporting hospital.

(d) Skilled Nursing/Intermediate Care Within This Hospital. A patient discharged to a Skilled Nursing/Intermediate Care Distinct Part within this reporting hospital.

(e) Acute Care at Another Hospital. A patient discharged to another hospital to receive inpatient care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of another hospital.

(f) Other Type of Hospital Care at Another Hospital. A patient discharged to another hospital to receive inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit of another hospital.

(g) Skilled Nursing/Intermediate Care Elsewhere. A patient discharged from this hospital to a Skilled Nursing/Intermediate Care type of care, either freestanding or a distinct part within another hospital, or to a Congregate Living Health Facility, as defined by Subsection (i) of Section 1250 of the Health and Safety Code.

(h) Residential Care Facility. A patient discharged to a facility that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

(i) Prison/Jail. A patient discharged to a correctional institution.

(j) Against Medical Advice. Patient left the hospital against medical advice, without a physician's discharge order. Psychiatric patients discharged from away without leave (AWOL) status are included in this category.

(k) Died. All episodes of inpatient care that terminated in death. Patient expired after admission and before leaving the hospital.

(l) Home Health Service. A patient referred to a licensed home health service program.

(m) Other. A patient discharged to some place other than mentioned above. Includes patients discharged to a freestanding, not hospital-based, inpatient hospice facility.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97232. Definition of Data Element for Inpatients—Expected Source of Payment.

(a) Effective with discharges on or after January 1, 1999, the patient's expected source of payment shall be reported using the following:

(1) Payer Category: The type of entity or organization which is expected to pay or did pay the greatest share of the patient's bill.

(A) Medicare. A federally administered third party reimbursement program authorized by Title XVIII of the Social Security Act. Includes crossovers to secondary payers.

(B) Medi-Cal. A state administered third party reimbursement program authorized by Title XIX of the Social Security Act.

(C) Private Coverage. Payment covered by private, non-profit, or commercial health plans, whether insurance or other coverage, or organizations. Included are payments by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, or Shriners.

(D) Workers' Compensation. Payment from workers' compensation insurance, government or privately sponsored.

(E) County Indigent Programs. Patients covered under Welfare and Institutions Code Section 17000. Includes programs funded in whole or in part by County Medical Services Program (CMSP), California Healthcare for Indigents Program (CHIP), and/or Realignment Funds whether or not a bill is rendered.

(F) Other Government. Any form of payment from government agencies, whether local, state, federal, or foreign, except those in Subsections(a)(1)(A), (a)(1)(B), (a)(1)(D), or (a)(1)(E) of this section. Includes funds received through the

California Children Services (CCS), the Civilian Health and Medical Program of the Uniformed Services (TRICARE), and the Veterans Administration.

(G) Other Indigent. Patients receiving care pursuant to Hill-Burton obligations or who meet the standards for charity care pursuant to the hospital's established charity care policy. Includes indigent patients, except those described in Subsection (a)(1)(E) of this section.

(H) Self Pay. Payment directly by the patient, personal guarantor, relatives, or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other health plan.

(I) Other Payer. Any third party payment not included in Subsections (a)(1)(A) through (a)(1)(H) of this section. Included are cases where no payment will be required by the facility, such as special research or courtesy patients.

(2) Type of Coverage. For each Payer Category, Subsections (a)(1)(A) through (a)(1)(F) of this section, select one of the following Types of Coverage:

(A) Managed Care - Knox-Keene/Medi-Cal County Organized Health System. Health care service plans, including Health Maintenance Organizations (HMO), licensed by the Department of Corporations under the Knox-Keene Health Care Service Plan Act of 1975. Includes Medi-Cal County Organized Health Systems.

(B) Managed Care - Other. Health care plans, except those in Subsection (a)(2)(A) of this section, which provide managed care to enrollees through a panel of providers on a pre-negotiated or per diem basis, usually involving utilization review. Includes Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Exclusive Provider Organization with Point-of-Service option (POS).

(C) Traditional Coverage. All other forms of health care coverage, including the Medicare prospective payment system, indemnity or fee-for-service plans, or other fee-for-service payers.

(3) Name of Plan.

(A) For discharges occurring on or after January 1, 2004, report the names of those plans which are licensed under the Knox-Keene Health Care Service Plan Act of 1975 or designated as a Medi-Cal County Organized Health System. For Type of Coverage, Subsection (a)(2)(A) of this section, report the plan code number representing the name of the Knox-Keene licensed plan or the Medi-Cal County Organized Health System as shown in Table 1.

Table 1. Plan Code Numbers for Knox-Keene Licensed Plans and Medi-Cal County Organized Health Systems:
For use with discharges occurring on or after January 1, 2004

Plan Names and Medi-Cal County Organized Health System Names	Plan Code Numbers
AET Health Care Plan Of California	0296
Aetna Health Plans of California, Inc.	0176
Alameda Alliance for Health	0328
American Family Care	0322
Avante Behavioral Health Plan	0397
Blue Cross of California	0303
Blue Shield of California	0043
Caloptima (Orange County)	0394
Care 1st Health Plan	0326
CareMore Insurance Services, Inc	0408
Cedars-Sinai Provider Plan, LLC	0366
Central Coast Alliance For Health (Santa Cruz County / Monterey County)	0401
Central Health Plan	0404
Chinese Community Health Plan	0278
Cigna Behavioral Health of California	0298
Cigna HealthCare of California, Inc.	0152
Community Health Group	0200
Community Health Plan (County of Los Angeles)	0248
Contra Costa Health Plan	0054
HAI, Hai-Ca	0292
Health Net of California, Inc.	0300
Health Plan of America (HPA)	0126
Health Plan of the Redwoods	0159
(The) Health Plan of San Joaquin	0338
Health Plan of San Mateo	0358
Heritage Provider Network, Inc.	0357
HHRC, Integrated Insights	0319
Holman Professional Counseling Centers	0231
Inland Empire Health Plan (IEHP)	0346
Inter Valley Health Plan	0151
Kaiser Foundation Health Plan, Inc.	0055
Kern Health Systems Inc	0335
Lifeguard, Inc.	0142
LA Care Health Plan	0355
Managed Health Network	0196
Medcore HP	0390
Merit Behavioral Care of California, Inc. (MBC)	0288
Molina Healthcare of California	0322

One Health Plan of California Inc.	0325
On Lok Senior Health Services	0385
PacifiCare Behavioral Health of California	0301
PacifiCare of California	0126
Primecare Medical Network, Inc.	0367
ProMed Health Care Administrators	0380
Regents of the University of California	0354
San Francisco Health Plan	0349
Santa Barbara Regional Health Authority	0400
Santa Clara Family Health Plan	0351
Santa Clara Valley Med. Ctr.	0236
SCAN Health Plan	0212
Scripps Clinic Health Plan Services, Inc.	0377
Secure Horizons	0126
Sharp Health Plan	0310
Simnsa Health Care	0393
Sistemas Medicos Nacionales, S.A. De C.V.	0393
Smartcare Health Plan	0212
Solano Partnership Health Plan (Solano County)	9048
The Health Plan of San Joaquin	0338
UHP Healthcare	0008
Universal Care	0209
U.S. Behavioral Health Plan, California	0259
Valley Health Plan	0236
ValueOptions of California, Inc.	0293
Ventura County Health Care Plan	0344
Vista Behavioral Health Plan	0102
Western Health Advantage	0348
Other	8000

(B) For discharges occurring on or after January 1, 2005 also include the additional plans listed.

Table 1a. Additional Plan Code Numbers for Knox-Keene Licensed Plans and Medi-Cal County Organized Health Systems:
For use with discharges occurring on or after January 1, 2005

Plan Names and Medi-Cal County Organized Health System Names	Plan Code Numbers
Blue Cross of California Partnership Plan	0415
Great-West Healthcare of California, Inc.	0325
Honored Citizens Choice Health Plan, Inc.	0414

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97233. Definition of Data Element for Inpatients—Prehospital Care and Resuscitation.

Effective with discharges on or after January 1, 1999, information about resuscitation orders in a patient's current medical record shall be reported as follows:

(a) Yes, a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital.

(b) No, a DNR order was not written at the time of or within the first 24 hours of the patient's admission to the hospital.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97240. Request for Modifications to Patient Data Reporting.

(a) Reporting facilities may file a request with the Office for modifications to Hospital Discharge Abstract Data, Emergency Care Data, or Ambulatory Surgery Data reporting requirements. The modification request must be supported by a detailed justification of the hardship that full reporting of data would have on the reporting facility; an explanation of attempts to meet data reporting requirements; and a description of any other factors that might justify a modification. Modifications may be approved for only one year. Each reporting facility with an approved modification must request a renewal of that approval 60 days prior to termination of the approval period in order to have the modification continue in force.

(b) The criteria to be considered and weighed by the Office in determining whether a modification to data reporting requirements may be granted are as follows:

(1) The modification would not impair the ability of either providers or consumers to make informed health care decisions.

(2) The modification would not deprive the public of data needed to make comparative choices with respect to scope or type of services or to how services are provided, and with respect to the manner of payment.

(3) The modification would not impair any of the goals of the Act.

(c) Reporting facilities that did not have any discharges or encounters that are required to be reported pursuant to Section 97213(a) for a specific report period must complete and submit a separate No Data to Report form (OSHPD 2005.1) as Revised on 09/26/2005 on or before the required due date of the report either by using the online screen available through the MIRCal system or by printing the online No Data to Report form and mailing or faxing it to the Office for that report period.

(d) Any facility that is not licensed to provide inpatient care, or does not provide

Emergency Care encounters, or does not provide outpatient procedures, or is not licensed as a surgical clinic, and from whom such reporting is not therefore expected, is not required to file a No Data to Report form.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735, 128736, 128737, and 128760, Health and Safety Code.

97241. Extensions of Time to File Reports.

(a) Extensions are available to reporting facilities that are unable to complete their submission of reports by the due date prescribed in Section 97211.

(1) Requests for extension shall be filed on or before the required due date of the report by using the extension request screen available through the MIRCal system or by using the Patient Data Reporting Extension Request (form DD1805) as revised 06/09/2005. Notices regarding the use of extension days, and new due dates, as well as notices of approval and rejection, will be e-mailed to the primary contact and Administrator e-mail addresses provided by the facility. If a Designated Agent e-mail contact address has been provided by the facility, this contact will also be notified. These notices will also be available to all facility MIRCal users on the MIRCal Submission Status page.

(2) The Office shall respond within 5 days of receipt of the request by either granting what is determined to be a reasonable extension or disapproving the request. The Office shall not grant extensions that exceed the maximum number of days available for the report period for all extensions. If a reporting facility submits the report prior to the due date of an extension, those days not used will be applied to the number of remaining extension days. A reporting facility that wishes to contest any decision of the Office shall have the right to appeal, pursuant to Section 97052.

(b) A maximum of 14 extension days will be allowed for all extensions and resubmittals of reports with discharges or encounters occurring on or after January 1, 2005.

(c) If a report is rejected on, or within 7 days before, or at any time after, any due date established by Subsections (c), or (d), of Section 97211, the Office shall grant, if available, an extension of 7 days. If less than 7 days are available all available extension days will be granted.

(d) If the Office determines that the MIRCal system was unavailable for data submission for one or more periods of 4 or more continuous supported hours during the 4 State working days before a due date established pursuant to Section 97211, the Office shall extend the due date by 7 days.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Section 128770, Health and Safety Code.

97244. Method of Submission.

(a) Reporting facilities shall use the MIRCal system for submitting reports. Data shall be reported utilizing a Microsoft Internet Explorer web browser that supports a secure Internet connection utilizing the Secure Hypertext Transfer Protocol (HTTPS or https) and 128-bit cypher strength Secure Socket Layer (SSL) through either:

(1) Online transmission of data reports as electronic data files, or

(2) Online entry of individual records.

(b) For Hospital Discharge Abstract Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges on or after January 1, 2003 by diskette, compact disk or Hospital Discharge Abstract Data Record Manual Abstract Reporting Form, provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission Patient Discharge Data as revised in April 2004. The version of the Manual Abstract Reporting Form (OSHPD 1370.IP) to be used is as revised on 03/17/2004. Copies of Form 1370.IP shall be made by the hospital to submit its discharge data and each additional copy shall be made on one sheet, front (Page 1 of 2) and back (Page 2 of 2).

(c) For Emergency Care Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report encounters on or after October 1, 2004 by diskette, compact disk or Emergency Care Data Record Manual Abstract Reporting Form (OSHPD 1370.ED), provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission Emergency Department and Ambulatory Surgery, dated January 2006. The version of the Manual Abstract Reporting Form (1370.ED) to be used is dated 01/01/2006. Copies of Form 1370.ED shall be made by the hospital to submit its encounter data and each additional copy shall be made on three sheets (Page 1 of 3), (Page 2 of 3), and (Page 3 of 3).

(d) For Ambulatory Surgery Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital or freestanding ambulatory surgery clinic may report encounters on or after October 1, 2004 by diskette, compact disk or Ambulatory Surgery Data Record Manual Abstract Reporting Form (OSHPD 1370.AS), provided the reporting facility complies with the Office's Format and File Specifications for MIRCal Online Transmission Emergency Department and Ambulatory Surgery, dated January 2006. The version of the Manual Abstract Reporting Form (1370.AS) to be used is dated 01/01/2006. Copies of Form 1370.AS shall be made by the hospital or freestanding ambulatory surgery clinic to submit its encounter data and each additional copy shall be made on three sheets (Page 1 of 3), (Page 2 of 3), and (Page 3 of 3).

Note: Authority: Section 128755, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97245. Online Test Option.

Reports may be tested before formal submission to the Office using the online test option. Online testing of reports through the MIRCal online test option before formal transmission is the recommended means of ensuring compliant data that meets the standards established by the Office before the due date. Reports tested through the online test option will be subject to the same processing and will generate the same reports as data that is formally submitted. Reports may be tested through the test option as many times as needed to assure that the reports meet the standards established by the Office in Section 97247.

Authority: Section 128755, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97246. Data Transmittal Requirements.

(a) Reporting facilities submitting their own data online must use the MIRCal Online Data Transmittal by Facility method to file or submit each report. The following information must be included: the facility name, the unique identification number specified in Section 97210, the beginning and ending dates of the report period, the number of records in the report and the following statement of certification:

I certify under penalty of perjury that I am an official of this facility and am duly authorized to submit these data; and that, to the extent of my knowledge and information, the accompanying records are true and correct, and that the applicable definitions of the data elements as set forth in Article 8 (Patient Data Reporting Requirements) of Chapter 10 (Health Facility Data) of Division 7 of Title 22 of the California Code of Regulations, have been followed by this facility.

(b) Reporting facilities that choose to designate an agent to submit their records must submit a hardcopy Agent Designation Form (OSHPD 1370.3, Revised: 06/09/2005), hereby incorporated by reference, to the Office's Patient Data Program. Receipt of a subsequent hardcopy Agent Designation Form supersedes the previous designation. Each reporting facility shall notify the Office's Patient Data Program within 15 days after any change in designated agent.

(c) An agent who has been designated by a reporting facility to submit that facility's data online must use the MIRCal Online Data Transmittal by Agent method to file or submit reports. The following information must be included: the facility name, the facility identification number specified in Section 97210, the beginning and ending dates of the report period, and the number of records in the report.

(d) Reporting facilities with an approved exemption to submit records using either Hospital Discharge Abstract Data Record Manual Abstract Reporting Forms (OSHPD 1370.IP, Revised: 03/17/2004), or Emergency Care Data Record Manual Abstract Reporting Forms (OSHPD 1370.ED dated 01/01/2006), or Ambulatory Surgery Data Record Manual Abstract Reporting Forms (OSHPD 1370.AS dated 01/01/2006), diskette, or compact disk, must submit a hardcopy Individual Facility Transmittal Form

(OSHPD 1370.1, Revised: 06/09/2005), hereby incorporated by reference. The Individual Facility Transmittal Form shall accompany the report.

(e) Agents who have been designated by a reporting facility to submit a facility's report in accordance with an approved exemption as described in (d) above must submit a hardcopy Designated Agent Transmittal Form (OSHPD 1370.2, Revised: 06/09/2005), hereby incorporated by reference. The Designated Agent Transmittal Form shall accompany the facility's report.

(f) A facility's administrator may designate no more than 3 User Account Administrators. For each User Account Administrator there must be an original signed User Account Administrator Agreement Form (OSHPD 2002.1, Revised: 01/05/2006), and hereby incorporated by reference), submitted to the Office.

(g) A signed Designated Agent User Agreement Form (OSHPD 2002.2, Revised: 01/05/2006), hereby incorporated by reference, must be submitted to the Office by an agent who has been designated to submit data online.

(h) Reporting facilities and designated agents may obtain copies of the forms from the OSHPD web site at www.oshpd.ca.gov or by contacting the Office's Patient Data Program at (916) 324-6147.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97247. Approval Criteria.

(a) The following requirements must be met for a report to be approved by the Office:

(1) Complete transmittal information must be submitted with each report.

(2) The facility identification number stated in the transmittal information must be consistent with the facility identification number on each of the records in the report.

(3) The report period stated in the transmittal information must be consistent with all of the records in the report.

(4) The number of records stated in the transmittal information must be consistent with the number of records contained in the report.

(5) All records required to be reported pursuant to 97213(a) must be reported.

(6) The data must be reported in compliance with the format specifications in Section 97215.

(7) The data must be at, or below, the Error Tolerance Level specified in Section 97248.

(8) The data must be consistent with the reporting facility's anticipated trends and comparisons, except as in (A) below:

(A) If data are correctly reported and yet are inconsistent with the reporting facility's anticipated trends and comparisons, the reporting facility may submit to the Office a written explanation detailing why the data are correct as reported. The Office may determine, upon review, that it will approve a report.

(9) Each report must contain only one type of record as specified in Subsections (1), (2), and (3) of Subsection (a) of Section 97213.

(b) The Office shall approve or reject each report within 15 days of receiving it. The report shall be considered not filed as of the date that the facility is notified that the report is rejected. Notification of approval or rejection of any report submitted online shall not take more than 15 days unless there is a documented MIRCal system failure.

Authority: Sections 128810, and 128755, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97248. Error Tolerance Level.

(a) The Error Tolerance Level (ETL) for data reported to the Office shall be no more than 2%. Errors as defined in Subsection (k) of Section 97212, must be corrected to the ETL.

(b) For hospital discharge abstract data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 1.

Table 1: Hospital Discharge Abstract Data Record Defaults	
Invalid Data Element	**Default**
Admission date	delete record
Discharge date	delete record
Principal Diagnosis	799.9
Condition Present at Admission for Principal Diagnosis	Yes
All other data elements	blank or zero

(c) For emergency care data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 2.

Table 2: Emergency Care Data Record Defaults	
Invalid Data Element	**Default**
Service date	delete record
Principal Diagnosis	799.9
All other data elements	blank or zero

(d) For ambulatory surgery data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 3.

Table 3: Ambulatory Surgery Data Record Defaults	
Invalid Data Element	**Default**
Service date	delete record
Principal Diagnosis	799.9
All other data elements	blank or zero

Authority: Section 128755, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97249. Hours of Operation.

The MIRCal System will be supported from 8:00 a.m. to 5:00 p.m., Monday through Friday (except for Official State Holidays). System maintenance may cause intermittent MIRCal system unavailability. Contact the Patient Data Program at (916) 324-6147 to report possible MIRCal transmission problems.

Authority: Section 128755, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97250. Failure to File a Data Report.

Any health facility which does not file any report completed as required by this article is liable for a civil penalty of one hundred dollars ($100) a day to be assessed and recovered in a civil action brought in the name of the people of the State of California by the Office for each day that the filing of the report is delayed, considering all approved extensions of the due date as provided in Section 97241. Assessed penalties may be appealed pursuant to Section 97052. Within fifteen days after the date the reports are due, the Office shall notify the health facility of reports not yet received, the amount of the liability, and potential future liability for failure to file reports when due. Sixty days after an original report due date as specified in Section 97211(c), the MIRCal system will close for that report period. No report for the period will be accepted after the MIRCal system closure. No additional penalties will accrue for outstanding reports after the MIRCal system closure for a report period.

Note: Authority: Sections 128755 (c)(3),(d),and (e), and 128810, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code

97251. Definition of Data Element for ED and AS—Date of Birth.

(a) For online transmission of data reports as electronic data files, the patient's date of birth shall be reported in numeric form as follows: the 4-digit year, the 2-digit month, and the 2-digit day. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

(b) For online entry of individual records, the patient's date of birth shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

(c) When the complete date of birth is unknown, as much of the date as is known shall be reported. At a minimum, an approximate year of birth shall be reported. If only the age is known, the estimated year of birth shall be reported and the month and day can be reported as 01 for month and 01 for day.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97252. Definition of Data Element for ED and AS—Sex.

The patient's gender shall be reported as male, female or unknown. Unknown indicates that the patient's sex was undetermined or not available from the medical record.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code

97253. Definition of Data Element for ED and AS—Race.

The race shall be as self-reported by the patient or patient's guardian in cases where the patient is not capable of providing the information. The patient's race shall be reported as one choice from the following list of alternatives under race:

(a) American Indian or Alaska Native
(b) Asian
(c) Black or African American
(d) Native Hawaiian or Other Pacific Islander
(e) White
(f) Other Race
(g) Unknown

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97254. Definition of Data Element for ED and AS—Ethnicity.

The ethnicity shall be as self-reported by the patient or patient's guardian in cases where the patient is not capable of providing the information. The patient's ethnicity shall be reported as one choice from the following list of alternatives under ethnicity:

(a) Hispanic or Latino Ethnicity
(b) Non-Hispanic or Non-Latino Ethnicity
(c) Unknown

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97255. Definition of Data Element for ED and AS—ZIP Code.

The "ZIP Code," a unique code assigned to a specific geographic area by the U.S. Postal Service, for the patient's usual residence shall be reported for each record. If the patient has a 9-digit ZIP Code, only the first five digits shall be reported. Do not report the ZIP Code of the hospital, third party payer, or billing address if it is different from the usual residence of the patient. If the patient's ZIP Code is not recorded in the patient's medical record, the patient's ZIP Code shall be reported as "not in medical record," by reporting the unknown ZIP Code as "99999."

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97256. Definition of Data Element for ED and AS—Patient Social Security Number.

The patient's social security number is to be reported as a 9-digit number. If the patient's social security number is not recorded in the patient's medical record, the social security number shall be reported as "not in medical record," by reporting the social security number as "000000001." The number to be reported is to be the patient's social security number, not the social security number of some other person, such as the mother of a newborn or the insurance beneficiary under whose account the hospital's bill is to be submitted.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97257. Definition of Data Element for ED and AS—Service Date.

(a) For online transmission of data reports as electronic data files, the patient's service date shall be reported in numeric form as follows: the 4-digit year, the 2-digit month, and the 2-digit day. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

(b) For online entry of individual records, the patient's service date shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97258. Definition of Data Element for ED and AS—Principal Diagnosis.

The patient's principal diagnosis, defined as the condition, problem, or other reason established to be the chief cause of the encounter for care, shall be coded according to the ICD-9-CM.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97259. Definition of Data Element for ED and AS—Other Diagnoses.

The patient's other diagnoses are defined as all conditions that coexist at the time of the encounter for emergency or ambulatory surgery care, that develop subsequently during the encounter, or that affect the treatment received. Diagnoses shall be coded according to the ICD-9-CM. ICD-9-CM codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) and codes from Morphology of Neoplasms (M800-M997 codes) shall not be reported as other diagnoses.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97260. Definition of Data Element for ED and AS—Principal External Cause of Injury.

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported on records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported on the record for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If the

E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the encounter record. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97261. Definition of Data Element for ED and AS—Other External Cause of Injury.

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported on the record for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the encounter record. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97262. Definition of Data Element for ED and AS—Principal Procedure.

The patient's principal procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk. The procedure related to the principal diagnosis, as the chief reason for the encounter, shall be selected as the principal procedure. The procedure shall be coded according to the Current Procedural Terminology, Fourth Edition (CPT-4).

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97263. Definition of Data Element for ED and AS—Other Procedures.

All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk. Procedures shall be coded according to the Current Procedural Terminology, Fourth Edition (CPT-4).

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97264. Definition of Data Element for ED and AS—Disposition of Patient.

The patient's disposition, defined as the consequent arrangement or event ending a patient's encounter in the reporting facility, shall be reported as one of the following:

(a) Discharged to home or self care (routine discharge).

(b) Discharged/Transferred to a short-term general hospital for inpatient care.

(c) Discharged/Transferred to a skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care.

(d) Discharged/Transferred to an intermediate care facility (ICF).

(e) Discharged/Transferred to another type of institution not defined elsewhere in this code list.

(f) Discharged/Transferred to home under care of an organized home health service organization in anticipation of covered skilled care.

(g) Left against medical advice or discontinued care.

(h) Expired.

(i) Discharged/Transferred to a Federal health care facility.

(j) Discharged home with hospice care.

(k) Discharged to a medical facility with hospice care.

(l) Discharged/Transferred to a hospital-based Medicare approved swing bed.

(m) Discharged/Transferred to an inpatient rehabilitation facility (IRF) including a rehabilitation distinct part unit of a hospital.

(n) Discharged/Transferred to a Medicare certified long term care hospital (LTCH).

(o) Discharged/Transferred to nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare.

(p) Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.

(q) Discharged/Transferred to a Critical Access Hospital (CAH).

(r) Other

Note: Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97265. Definition of Data Element for ED and AS—Expected Source of Payment.

The patient's expected source of payment, defined as the type of entity or organization which is expected to pay or did pay the greatest share of the patient's bill, shall be reported using the following categories:

(a) Self-pay. Payment directly by the patient, guarantor, relatives or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other third party.

(b) Other Non-Federal Programs. Include any form of payment from local, county, or state government agencies. Include payments from county funds, whether from county general funds or from other funds used to support county health programs. Include County Indigent Programs, County Medical Services Program (CMSP), California Healthcare for Indigent Program (CHIP), County Children's Health Initiative Program (C-CHIP), and Short-Doyle funds. Also include the State Children's Health Insurance Program (SCHIP), Managed Risk Medical Insurance Board (MRMIB), Healthy Families Program (HFP), and Access for Infants and Mothers (AIM).

(c) Preferred Provider Organization (PPO).

(d) Point of Service (POS).

(e) Exclusive Provider Organization (EPO).

(f) Health Maintenance Organization (HMO) Medicare Risk. Medicare is defined by Title XVIII of the Social Security Act (42 USC 1395 et seq.) and Title I of the Federal Medicare Act (PL 89-97). Include Medicare patients covered under an HMO arrangement.

(g) Automobile Medical. Include PPO, POS, EPO, HMO and Fee for Service or any other payment resulting from automobile coverage.

(h) Blue Cross/Blue Shield. Include only Fee for Service payments. Report PPO, POS, EPO, and HMO under the appropriate stated categories.

(i) CHAMPUS (TRICARE). Include any PPO, POS, EPO, HMO, Fee for Service, or other payment from the Civilian Health and Medical Program of the Uniformed Services or from TRICARE.

(j) Commercial Insurance Company. Report payment from insurance carriers on a Fee for Service basis. Exclude PPO, POS, and EPO, payments.

(k) Disability.

(l) Health Maintenance Organization (HMO). Report HMO payors. Include Knox-Keene licensed plans as well as out of State HMO plans. No Plan Code Number or Plan Code Name is required for ED or AS records. Report Medicare payments covered under an HMO arrangement as Health Maintenance Organization (HMO) Medicare Risk. Report Medi-Cal payments covered under an HMO arrangement as Medicaid.

(m) Medicare Part A. Defined by Title XVIII of the Social Security Act. Covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

(n) Medicare Part B. Defined by Title XVIII of the Social Security Act. Covers some outpatient hospital care and some home health services.

(o) Medicaid. Medicaid is called Medi-Cal in California. Defined by Title XIX of the Social Security Act and Title I of the Federal Medicare Act (PL 89-97). Report all Medi-Cal including Fee for Service, PPO, POS, EPO, and HMO.

(p) Other Federal Program. Report federal programs not covered by any other category.

(q) Title V. Defined by the Federal Medicare Act (PL 89-97) for Maternal and Child Health. Title V of the Social Security Act is administered by the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services. Include a Maternal and Child Health program payment that is not covered under Medicaid (Medi-Cal). California Children Services (CCS) payments should be reported here.

(r) Veterans Affairs Plan. Include any PPO, POS, EPO, HMO, Fee for Service, or other payment resulting from Veterans Administration coverage.

(s) Workers' Compensation Health Claim. Payment from Workers' Compensation Health Claim insurance should be reported under this category.

(t) Other. Include payment by governments of other countries. Include payment by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, Shriners, etc. Include payments not listed in other categories.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97266. Freestanding Ambulatory Surgery Encounter Fee Assessment

(a) The Office shall mail an annual notice of special fee assessment, as provided in Section 90417, and a remittance advice form to each freestanding ambulatory surgery clinic. The annual notice of special fee assessment and remittance advice form shall be mailed at least 20 days before the fee due date. The remittance advice form shall be completed by each surgical clinic and returned to the Office with full payment of the special fee amount. The fee shall be due on July 1st and delinquent on July 31st of each year. The basis of assessment is the number of ambulatory surgery data records submitted to the Office for encounters in the preceding calendar year.

(b) New surgical clinics which had no encounters in the previous calendar year are not liable for the initial special fee.

(c) New surgical clinics that have been operating for less than 12 months in the previous calendar year are liable for the special fee based on the number of ambulatory surgery data records submitted to the Office for encounters during the period of their licensed operations in the previous calendar year.

(d) Where there was a change in licensee during the prior calendar year, the current licensee shall be assessed a special fee based on the number of ambulatory surgery data records submitted to the Office for encounters that occurred during the time of their licensure.

(e) The Office shall determine the basis of assessment for special fee amounts due from surgical clinics in those circumstances not specifically covered above.

(f) To enforce payment of delinquent special fees, the Office shall notify the State Department of Health Services not to issue a license and not to renew the existing license of the delinquent surgical clinic until the special fees have been paid, pursuant to Section 127280, Health and Safety Code. A copy of the Office notice to the State Department of Health Services shall be sent to the delinquent surgical clinic.

Note: Authority: Section 127150, 127280, and 128810, Health and Safety Code.
Reference: Section 127280 and 128737 Health and Safety Code.